PRESBYTERIAN

Kidney Transplant Services Recipient Evaluation

Background Information Form/Social Worker Assessment

Please read before completing this form

***

This form is intended for potential transplant recipients.

You may complete this form, to the best of your ability, and mail or fax to Presbyterian Transplant Services.

Address: Presbyterian Transplant Services
201 Cedar Ave SE, Suite 820
Albuquerque, NM 87106

Fax number: (505) 222-2149

Please use this as the cover sheet when sending completed form.

If you would like to speak with a Transplant team member before completing this form, please call **(505) 841-1434**.

Once we receive the completed form, a Transplant team member will contact you to complete a new patient intake and schedule you to attend the Transplant Orientation Class.

NAME:_____

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Instructions: ***Please fill out all the items on this form. Please print your name at the bottom right of each page.***

PATIENT INFORMATION

Name: _____ **Date:** _____

Address: _____**City:** _____**State:** _____**Zip Code:** _____

Home Phone: _____**Work Phone:** _____**Cell:**_____

Social Security #: _____**DOB:** _____ **Age:** _____

Birthplace: _____ **Are you a US Citizen? Yes ☐ No ☐**

Immigration Status: _____ **Are you a Veteran? Yes ☐ No ☐**

Ethnicity: _____ **Race:** _____ **Religious Preference:** _____

Primary Language Spoken: _____ **Language of Origin** _____

Relationship Status: Single ☐ In Relationship ☐ Life Partner ☐ Married ☐ # of Years _____

Emergency Contact: _____ **Emergency Phone #**_____

Relationship to emergency contact: _____

Do you live in: House ☐ Apartment ☐ Mobile Home ☐ Own ☐ Rent ☐

Who do you live with? (List Names & Relationships): _____

_____

Do you have pets? Yes ☐ No ☐ Please List: _____

EMPLOYMENT/EDUCATION

Highest Level of Education Completed: _____

Your Usual Occupation: _____ **Currently Employed? Yes ☐ No ☐**

If yes, where? _____ **For how long?** _____

☐ **Full Time** ☐ **Part Time**

If No, when and where did you last work? _____

Reason for leaving: _____

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Are you on disability? Yes ☐ No ☐ **Type of benefit (SSD, SSI, etc.): _____**

If so when was your disability start date_____ Cause of disability: _____

SPOUSE / SIGNIFICANT OTHER

Spouse/ Significant other's name: _____ DOB: _____

Highest level of education completed: _____

Employer: _____ Currently employed Yes ☐ No ☐

Position: _____

FAMILY INFORMATION

Mother's Name: _____ Living ☐ Deceased ☐

Father's Name: _____ Living ☐ Deceased ☐

Do you have brothers and sisters? Yes ☐ No ☐

Names and ages of brothers and sisters?

_____

_____

Do you have children? Yes ☐ No ☐

Name & Ages of Your Children: _____

_____

Significant information about your children:

_____

_____

Describe your relationship with your family: _____

_____

_____

Who do you most often look to for emotional support? _____

_____

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INSURANCE INFORMATION

Primary Insurance Company: _____ **ID #** _____

Secondary Insurance Company: _____ **ID #** _____

Name of your prescription plan? _____ **Medication co-pay?** _____

Have you ever applied for, or been on Medicaid? Yes ☐ No ☐

LIVING WILL

Do you have a living will? Yes ☐ No ☐ **Do you have a durable power of attorney? Yes ☐ No ☐**

RENAL MEDICAL HISTORY

Cause of your renal failure? _____

Are you on dialysis? Yes ☐ No ☐ **Type of dialysis: Hemo ☐ PD ☐**

Dialysis Center: _____ **Date dialysis started:** _____

How is dialysis going? _____

Do you or have you ever had a weight problem? Yes ☐ No ☐ When? _____

Are you on a special diet? Yes ☐ No ☐ If yes, what kind? Renal ☐ Diabetic ☐ Other _____

LIFESTYLE

How has your illness affected your lifestyle? _____

_____

How do you cope with your illness and lifestyle changes? _____

_____

What are your hobbies and activities? _____

What are the main causes of stress in your life? _____

_____

How do you handle stress? _____

_____

Have you ever been depressed? Yes ☐ No ☐ **Have you ever attempted suicide? Yes ☐ No ☐**

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Have you ever had problems with anxiety? Yes ☐ No ☐

Have you ever participated in counseling? Yes ☐ No ☐ If yes, When? _____

Why? _____ Was it helpful? Yes ☐ No ☐

Were you treated with medication or therapy? Yes ☐ No ☐

Are you open to counseling? Yes ☐ No ☐

Have you even been hospitalized for psychiatric reasons? Yes ☐ No ☐

Are you sexually active? Yes ☐ No ☐ If yes, do you use protection/birth control? Yes ☐ No ☐

If yes, what type of protection/ birth control do you use? _____

Do you smoke now? Yes ☐ No ☐ How much? _____

Have you ever smoked/chewed tobacco? Yes ☐ No ☐ For what time period? _____

If yes when did you quit?_____ Are you interested in a smoking cessation program? Yes ☐ No ☐

Do you currently drink alcohol? Yes ☐ No ☐

Beer: Yes ☐ No ☐ Wine: Yes ☐ No ☐ Mixed Drink: Yes ☐ No ☐ Other: Yes ☐ No ☐

How often? Daily ☐ Weekly ☐ Occasionally ☐

Did you drink in the past? Yes ☐ No ☐ How Long? _____ How much? _____

Have you ever had a DWI (Driving While Intoxicated/Impaired)? Yes ☐ No ☐

Have you ever been called a "problem drinker" or "alcoholic"? Yes ☐ No ☐

Have you ever participated in AA? Yes ☐ No ☐

Have you ever been in court ordered treatment? Yes ☐ No ☐

Do you use recreational drugs? Yes ☐ No ☐ Type (Pot, Crack, Cocaine, etc.) _____

Did you in the past? Yes ☐ No ☐ If yes, what and when? _____

Have you ever served time in jail/prison? Yes ☐ No ☐

When? _____ Why? _____

Have you ever been on Probation/Parole? Yes ☐ No ☐

When? _____ Why? _____

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MEDICATIONS

Who keeps track of your medications?

Self ☐ Spouse/Life Partner ☐ Family Member ☐ Other ☐

Do you know your medications? Yes ☐ No ☐

Do you sometimes forget to take your medication? Yes ☐ No ☐ If so how Often? _____

POST-TRANPLANT CARE

Who will provide care and support to you during the transplant experience? _____

_____

Who will care for you after your transplant? _____ Relationship: _____

Who will provide transportation after your transplant? _____ Relationship: _____

Does your support person have vacation time, or the ability to take a leave of absence, to assist you during and after your transplant? Yes ☐ No ☐

If you live outside of the Albuquerque area, will staying in Albuquerque after your transplant be a financial strain for you? Yes ☐ No ☐

Do you, or your family need assistance with lodging accommodations during your transplant recovery period? Yes ☐ No ☐

What are your main concerns about being a candidate for a transplant? _____

_____

_____

POTENTIAL DONOR(S)

Do you know anyone who wants to donate a kidney to you? Yes ☐ No ☐

If yes, who and your relationship to them?_____

_____

Are you comfortable accepting a living donor kidney? Yes ☐ No ☐

Who filled out this background information form? Self ☐ Other ☐